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EPIDERMOID CARCINOMA OF THE TONGUE

A Study Based On Ninety-Five Cases

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EPIDERMOID CARCINOMA of the tongue has long been recognized as a difficult and perplexing lesion to treat because of its rapidly invasive characteristics, the difficulty in removing the tumor without damaging important structures, and because of the advanced progress of the disease when the patient first seeks aid. Recent improvement and expansion of surgical techniques have stimulated our interest in this problem and we have reviewed the cases in the Rhode Island Hospital Tumor Clinic both to determine our past results and to look for ways of future improvement. Our figures parallel those of others in most instances, but certain findings such as the high percentage of cures in small lesions and the eventual outcome in "cured" cases were of particular interest to us.

Selection of Cases

The study is based on ninety-five cases seen from 1930 through the end of 1945. They are consecutive insofar as possible. Six cases were discarded because they were seen only once in consultation. Five could not be adequately studied because of lack of data concerning initial treatment given elsewhere.

TABLE I gives the age and sex incidence of the group.

TABLE I

Age	*No. Cases*	
30-39 yrs.	1	89.5% male
40-49 yrs.	5	10.5% female
50-59 yrs.	22	
60-69 yrs.	43	
70-79 yrs.	21	
80-89 yrs.	3	
	95	

These figures are not remarkable except as they show the marked predominence of males found in all groups of oral carcinoma. Now that smoking is not confined to one sex, tobacco can no longer be heavily implicated and there is no adequate explanation of the sex difference.

Wasserman or Hinton tests or both were done on all patients except one. Twenty-two or 24.5% were found positive. The correlation between lues and carcinoma of the tongue has long been known and is probably related to the leukoplakia and atrophic glossitis of latent syphilis. It is interesting that of twenty-four consecutive floor of the mouth carcinomas seen in the clinic there were no positive serologies.

The tumors were graded as in the following table.

TABLE II

Grade	*No. Cases*
I	15
II	44
III	16
IV	3
Not graded	4
No biopsy	13
	95

This shows the usual high incidence of the higher grades of tumor. Although this is in direct contradistinction to the lip tumors which are largely Grade I and have a good prognosis, we could not find that the lower grades in this series had better survival rates. This is perhaps in part because the slower growing tumors are not alarming to the patient who does not seek help until late. Five of our Grade I tumors involved the entire tongue, or nearly so, when first seen.

End Results

In the group of cases described above we were able to find only fifteen or 15.8% three year cures. Although this study is based primarily on three year cure rates we note that of the eighty-four cases

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followed five years there were ten or 11.9% five year cures. These figures could be compared with innumerable series of which we will quote only two of the larger. Taylor and Nathanson[1] found 14.4% three year cures in 822 cases, and Martin et al[2] reported 22.3% five year cures in 556 cases.

Treatment of Tongue Lesions

In attempting to break down our figures we find that thirty-three cases were given only palliative radiation therapy because of far advanced disease. Of the remaining sixty-two treated for cure, forty-seven had radiation not combined with surgery; among these there were eleven or 23.4% three year cures. In most instances these cases had preliminary X-radiation followed by insertion of radon seeds or radium needles. Four received X-ray alone.

Fifteen cases had surgery for their primary therapy, some with additional radiation in one form or another. Of these, four, or 26.6%, were three year cures. This is not a significant difference from that noted in the radiation group. Nevertheless, we feel that, using the newer more extensive operations for favorably placed lesions, we should be able not only to raise this figure appreciably, but also increase the number of resectable cases.

Although we favor further extension of surgical procedures we must point out that in comparing figures on surgery and radiation one must always bear in mind that the smaller lesions are much more apt to be chosen for surgery.

End Results of "Cured" Cases

In the follow-up of our three year cures we find that seven are living and well after from three to ten years while four died of other disease after from four to thirteen years. Of greatest interest are the remaining four who died of recurrent carcinoma of the tongue five, six, eight, and thirteen years after their original "cures."

We further note that of the fifteen three year cures only ten received local cures of the tongue by their initial therapy. Seven of these were treated by radiation and three by surgery plus supplementary radiation. One of these ten later had a simple excision of carcinomatous neck nodes and another had a radical neck dissection for positive nodes before cures were effected. The five remaining three year cures had their local tongue lesions eradicated only on the second or third attempt as follows:

First Therapy	*Second*	*Third*
Surgery	Radon	0
Radon	Surgery	0
Radium	X-ray and radium	0
X-ray	Radon	0
X-ray	Radium	Surgery

Thus, including the two cases who had positive neck nodes removed, seven of fifteen needed further therapy to tongue or neck before cure was effected.

In view of the preceding findings of very late relapses and of cases cured on the second or third attempt, it seems self evident that individuals with epidermoid carcinoma of the tongue must be followed for life at frequent intervals: certainly every three months. If one pursues the policy of yearly check-ups for five years one will miss an opportunity for improving the meagre salvage rates by treating recurrences early.

Size in Relation to Prognosis

Undoubtedly the most important factor in survival is not the type of treatment, but how soon it can be instituted. The large size these lesions reach before they are seen in the clinic is appalling. About one-third of the tumors are sufficiently far back on the tongue to be unrecognizable to the patient until they have reached considerable size. Nevertheless the tendency to consider the tumor an obstinate canker sore has been fatal to many. We are glad to state that only rarely is a physician to blame. Usually the patients do not seek aid of anyone. Table III shows the relation of size to three year cures. Unfortunately in fourteen of our cases no data is given on size. In twenty-one others, where actual size is not recorded, description of the area occupied by the tumor makes it in the neighborhood of three centimeters or over. These are classified as "large."

TABLE III

Size	*Total Group*		*3 Yr. Cure Group*
Less than 1 cm.	2	50% cure here	0
1.0-1.9 cm.	12		7
2.0-2.9 cm.	21		1
3.0-3.9 cm.	19		2
4.0-4.9 cm.	5		1
5.0-5.9 cm.	1		0
Large	21		1
? size	14		3
	95		15

It will be seen that in the lesions under 2 cm. in diameter there is a 50% three year cure rate. Unfortunately this group comprises only 17.3% of the tumors whose sizes are known. We feel that this is the greatest single factor in low cure rates.

Lymph Node Metastasis

Some idea of the advanced state of the disease when first seen can be gained from the fact that forty-five of the ninety-five had clinically positive nodes at their first visit. The fact that some of these may have been inflammatory is probably more than balanced by the cases that had non-palpable cancerous nodes. We can gain no idea of our percentage of accuracy in node diagnosis because many of

the cases were too far advanced for anything but palliative radiation, and neck biopsies were not done.

The thirteen major neck dissections in the series may be described as follows:

Complete lateral neck dissection	9
Complete lateral neck dissection except jugular vein not removed	2
Supra-omohyoid dissection	1
Bilateral upper neck dissection	1
	13

Although preoperatively nodes were thought to be positive in all these cases no tumor cells could be found in three of the specimens.

Results in this group were discouraging. Two died on the first post-operative day. Death in one was due to a heroic attempt to excise all the tumor by removing the invaded carotid artery including its bifurcation. Work of Rogers[3] and others has since shown that the common carotid, but not the internal, can usually be tied without interfering with cerebral circulation. The other case went into circulatory collapse twenty-four hours post-operatively and died within a few moments. Complete post-mortem examination failed to reveal the cause of death.

Of the remaining eleven neck dissections ten died of recurrent carcinoma in from three months to five and one-half years. One is living and well without recurrence after seven years.

These rather dismal figures have led us to look for ways of improving our results. It has been the policy of the clinic to wait for palpable nodes before recommending neck dissection. However, the disease is so difficult to cure once it has a good start in the neck, that we now feel that certain cases with apparent local cure should be selected for prophylactic neck dissections. There are no adequate figures to support this course, but it seems reasonable to believe that some of the younger individuals are entitled to this insurance.

In the cases in which neck dissection follows appearance of nodes the dissection should certainly be done as soon as the nodes are even questionable. However, one tends to wait another two weeks, and then two weeks more, to be sure that there is tumor present. We were both surprised and chagrined to find that our clinic had fallen into this error several times. Of our thirteen neck dissections only three were done within the first fortnight after nodes were first thought to be cancerous. Time interval between the finding of nodes and neck dissection is given in the following table:

TABLE IV

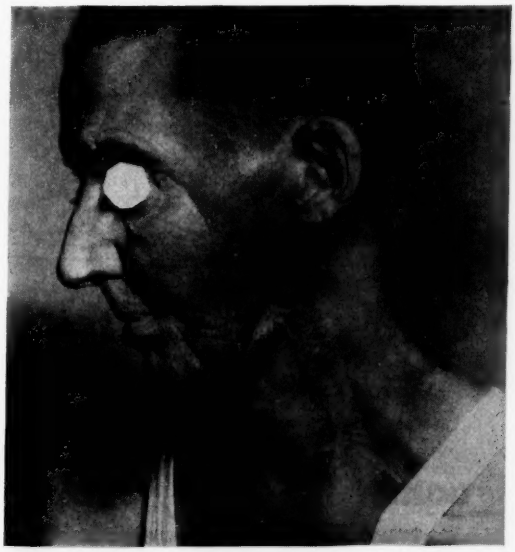
Time	*No. of Patients*
0-7 days	3
8-14 days	0
15-21 days	0
22-28 days	2
1-2 mos.	3
2-3 mos.	3
3-4 mos.	1
6 mos.	1
	13

Discussion

As has been noted frequently in the foregoing pages we lean towards earlier and more radical surgery than has been exercised in the past. Most lesions in the anterior half of the tongue are resectable. At the very least, one centimeter margin of normal tissue should be taken with specimens and hemiglossectomy may be the advisable procedure. In certain instances where the tongue lesion is more extensive, a wide margin of safety can be exercised by doing a hemiglossectomy, removal of half the mandible including its articulation, and a homolateral neck dissection in one stage as practiced in some of our leading clinics. The accompanying photograph *(Fig. 1) show the surprisingly little disfiguration which results from such a radical procedure. The patient talks adequately and eats a semisolid diet.

Recently one of us (E. S. C.) has performed a total glossectomy for a carcinoma of nearly the entire tongue (Figs. 2 & 3). This patient, who has no recurrence after two years, eats and talks better than when he had a mouthful of carcinoma.

Of course, there will still be a large proportion of far advanced tumors, posterior tongue lesions, and cases with bilateral neck involvement that must still be treated by palliative radiation.



1. Post-operative result following hemiglossectomy; removal of 2/5 of the jaw including the articulation, and radical neck direction in one sitting.

*We are indebted to Dr. Eske Windsberg for permission to show pictures of this case.

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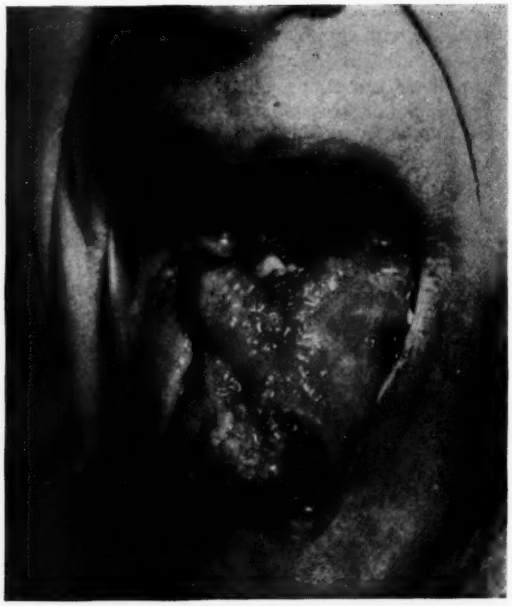

2. Pre-operative view of extensive Grade I Carcinoma.

3. Same case as in Figure 2 after total glossectomy. The patient speaks and eats better than pre-operatively.

The problem of post-operative radiation is a perplexing one. In general we are against it until recurrence appears, unless it is fairly obvious that diseased tissues have been left behind.

As previously stated we feel that neck dissections are indicated as soon as nodes are palpated if the tongue lesion is controlled. In certain individuals we are now willing to advocate prophylactic neck dissections.

Summary

1. Ninety-five cases of epidermoid carcinoma of the tongue have been reviewed. Statistics on age, sex, and grade are given.
2. A 15.8% three year cure rate is recorded with no significant superiority being found for either surgery or radiation therapy.
3. Many of our cures were not effected until the second or even third attempt to eradicate the tumor. Several recurrences appeared after three years. Frequent check-up visits for life are therefore advocated.
4. A 50% three year cure rate is recorded in a small group of cases with lesions measuring less than 2 cm. in diameter.
5. Results in neck dissections are poor. Only one three year cure is recorded in this series.
6. A plea is made for more radical and earlier surgery both in tongue and neck to improve present poor results.

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UNDECYLENIC ACID TREATMENT IN PSORIASIS*

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"PSORIASIS is a chronic inflammatory disease, occasionally acute, characterized by formation of papules which leave a dull red base and are covered by imbricated micacious scales."[1] The lesions vary from a few isolated papules to numerous thickened plaques forming gyrate and cirinate configurations.

The elbows, knees, scalp, trunk, and sacral regions are most often afflicted, and the nails, palms or soles may be affected without evidence of lesions elsewhere. Psoriasis of the nails give characteristic stippling and accumulation of hyperkeratotic material beneath the nail which subsequently causes separation. In the scalp thickened plaques usually are limited to hairy areas, but occasionally extend on to the face. Psoriasis may also involve the moist folds, the groin for instance; and beneath the breasts, however, lesions of this variety are erythematous exudative and less characteristic. This type frequently is mistaken for a Fungus infection.

Although Psoriasis is a disease of all ages, it predominately affects persons over twenty years old. It is known to remain localized in sites of predilection for years with periods of quiescence and recurrences. Symptoms such as itching and burning are not a factor in most cases; but, the tendency to recurrence is a prominent feature of Psoriasis.

Its cause is still unknown; however, there is some evidence which points to disturbance in lipoid metabolism, and many investigators have noticed the hereditary influence in about twenty-five per cent of the cases.

*Presented at the John F. Kenney Annual Clinic of the Memorial Hospital Internes' Alumni Association, at Pawtucket, R. I., November 2, 1949.

Undecylenic Acid was reported for the treatment of Psoriasis by Dr. Henry Perlman of Philadelphia in February 1949. Formerly, this treatment had been employed in cases of ringworm of the scalp. Following the use of Undecylenic Acid there was profuse desquamation of the scalp which suggested that it might be effective in the treatment of Psoriasis. Dr. Perlman feels that sub-acute and chronic cases can benefit most from this treatment. He noted the following in his work: "Exfoliation of the lesions is preceded by a drying of the scales, which at times become friable and break off, leaving a somewhat reddened skin without bleeding points.[2]

I have seven cases to report, four private, three clinic. The dosage employed at first was the amount suggested in Dr. Perlman's first papers: Five perls, each containing .44 grams given three times daily before or after meals. The dosage given in later months was in accordance with that in Dr. Perlman's last article of July 9th: five perls each, three times daily, containing .44 grams of Undecylenic Acid are taken for three days. Five are taken between breakfast and lunch, five between lunch and supper, and five before the patient goes to bed. The next three days ten perls are taken three times daily, and this followed with fifteen perls three times daily continued for an indefinite period of time.

Dr. Perlman, in his original paper, casually mentions such symptoms as nausea, vomiting and diarrhea resulting from the drug. These symptoms, he says, can be alleviated by carbonated waters, but I was unable to get the called-for results with my patients.

I feel that this treatment has no actual value in that my private patients had a great deal of difficulty in tolerating this drug; they went through hard-

Patient	*Sex*	*Marital Status*	*Age*	*Type*	*Duration*	*Treatment Began*	*Total Days*	*Improvement*
M. S.	F.	M.	58	Chronic Generalized	20 yrs.	Mar. 29, '49	3 mos.	none
O. G.	M.	M.	38	"	4 yrs.	May '49	3 mos.	"
F. W.	M.	M.	37	"	10 yrs.	Mar. '49	2½ mos.	"
J. M.	M.	M.	57	"	17 yrs.	Mar. '49	4 mos.	"
S. S.	M.	S.	24	"	8 yrs.	Apr. '49	5 mos.	"
L. H.	F.	S.	14	"	8 yrs.	May '49	4 mos.	"
R. M.	F.	M.	26	sub-acute	1 yr.	Mar. '49	6 mos.	all cleared up

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CARCINOMA OF THE ENDOMETRIUM*

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THE problem of diagnosis and treatment of carcinoma of the endometrium differs markedly from that of carcinoma of the cervix. There are certain basic differences.

Incidence

Though carcinoma of the endometrium occurs far less frequently than carcinoma of the cervix, a ratio of about 1:5, it makes its appearance sufficiently often to be regarded with more respect than is frequently accorded. After the menopause four of every ten women who consult a physician because of the reappearance of bleeding after one or more years of amenorrhea will have endometrial carcinoma.

Age Incidence

The peak incidence for carcinoma of the cervix is about 45 years of age which is ten years younger than that for cancer of the endometrium. Bleeding after the menopause is associated in our teaching with carcinoma of the endometrium but it is well to bear in mind that the difference in frequency of the two neoplasms is such that cervical cancer, as a cause of postmenopausal bleeding, must be ruled out.

Economic Status

Cervical neoplasm is most frequently encountered in the clinic while carcinoma of the fundus is commonly found in women who appear in the private offices. The factors of early marriage, repeated pregnancies, poorer obstetrics and hygiene common to the lower income group may have a bearing on the higher incidence of cancer of the cervix.

Predisposing Factors

There are certain predisposing factors that call attention to the fact that any one patient may be a more likely candidate for cancer of the endometrium than another. Most of this information is available from the history. The patients are frequently so obese and there is so much associated pathology that the diagnosis is commonly not made until the time of actual diagnostic curettage. There are certain elements in the history however, which may prove helpful in establishing a diagnosis.

Body Types

It is a common observation that patients with carcinoma of the endometrium tend to be *obese.* Moss using standard tables for age and height found the women in his series to be about 10% over weight on the average. This according to Corscaden is about nine times the probable error. Not only are these women obese but they actually look larger than they really are for they are prone to have small hands and feet and large rounded hips. This is not an accident but rather an indication of basic endocrine imbalance.

Because they are obese they also tend to have diabetes and hypertension.

Late Menopause

There is much circumstantial evidence to indicate that the delayed menopause so commonly associated with cancer of the endometrium is of diagnostic significance. Randall could find but 8% of women without cancer in the uterus who continued to bleed after the age of 50. On the other hand 35% of the patients who developed carcinoma had bleeding after the age of 51. It has been suggested that the prolonged menopause may provide a longer time during which estrin may stimulate a susceptible uterus with resultant increase in carcinoma. It is interesting to note that cancer of the fundus rarely appears in a woman who is having hot flashes. Inspection of the vagina reveals a bluish moist vaginal epithelium indicative of estrin activity.

Marital Status

The percentage of nulliparous women among patients with cancer of the cervix is about 10% compared with 28-35% for carcinoma of the fundus.

*Presented at the 2nd Annual Cancer Conference for Rhode Island Physicians, at Providence, October 26, 1949.

Note: This article is one part of Doctor Parson's discussion of the topic "Cancer of the Uterus" presented at the Conference.

These women marry as frequently but the number of infertile marriages is definitely higher. This could indicate that cancer develops in the unused organ but it could also suggest that there was something wrong with the uterus from the beginning.

Irregular Menstrual Pattern

As a further suggestion that endometrial carcinoma may appear in the unused uterus it is interesting to observe the number of patients who past or present exhibit an abnormal bleeding pattern. One third to one half of the patients who develop carcinoma of the endometrium before the menopause show long standing gross abnormalities of menstruation. The same history is obtained among those who develop cancer of the fundus in the postmenopausal period. Nineteen percent have a history of curettage for previous abnormal bleeding. As further evidence many of these patients have received radium to control profuse irregular bleeding some years previously. In all probability the radiation did not give rise to the carcinoma though it certainly did not protect it from subsequently developing it. The most likely assumption is that there is something fundamentally wrong with the uterus. The abnormal bleeding for which the radium was given is an indication of it. Such a uterus is abnormally sensitive to such a stimulation as estrin and if continued long enough it contains within itself the potentiality of developing malignant disease.

We have noted from the history that many obese women of sound economic status are either unmarried or infertile. Frequently these women have a long history of abnormal menstrual bleeding preceding a delayed menopause marked by excessive flow. If we keep in mind that bleeding abnormalities at the climacteric are three times as common among patients who have carcinoma of the fundus as in normal women and that such patients are four times as likely to develop such a cancer then our attention becomes focused on this group as likely candidates to have carcinoma of the endometrium.

Physical Examination

Unfortunately the physical examination does not give as much information as to the location or extent of the lesion as is true of carcinoma of the cervix. The disease is located within a blind cavity and cannot be seen or felt as in carcinoma of the cervix. The local examination may be inconclusive largely because of the obesity. For example if a mass is felt above the symphysis on abdominal examination it may represent extensive carcinomatous infiltration producing a large uterus or it may be a large fibroid. On the other hand a small early carcinoma may be present in a large fibroid uterus. About 35% of patients with carcinoma of the fundus have fibroids in association.

The important thing to keep in mind is that the physician must not allow the associated pathology to distract his attention from the possibility of carcinoma within the uterus and delay performing an inspection of the cervix and diagnostic curettage.

Inspection of the cervix is of great importance for the disease may have extended down from the fundus to involve the cervix or the symptoms may arise from an epidermoid carcinoma within the cervical canal.

Symptoms

The symptoms are bleeding, discharge, pain, weight loss and anemia. Of these the only important symptom is abnormal bleeding.

The character of the bleeding depends upon the age of the patient at the time the malignancy develops. About 75% of the patients with fundal carcinoma will be in the postmenopausal period with 25% still in the reproductive era.

The character of the bleeding varies. It may manifest itself as (1) irregular bleeding with a tendency to increasing quantity of flow. This type of bleeding is characteristic of that group who develop carcinoma before the menopause. (2) Irregular spotting either continuous or intermittent and of no great amount. Rarely is it aggravated by coitus or douches. (3) Minimal spotting or staining in the postmenopausal period. This is commonly intermittent in frequency. (4) Sudden gushing of blood. This is not uncommon in the younger group as an intermenstrual phenomenon but it also occurs years after the menopause.

These types of bleeding are well-known to the medical profession yet the significance of postmenopausal bleeding as a herald of malignancy seems at times to be sadly overlooked. There seems to be a tendency to explain away the symptoms rather than investigate them. Smith found that 9% of the total number of 360 patients with carcinoma had been mismanaged because of the failure to consider carcinoma of the endometrium as the most important cause of abnormal bleeding at the time of the menopause. As an example the use of x-ray therapy without a preliminary curettage may be cited.

While cancer of the endometrium may appear relatively slow growing, early diagnosis and treatment reflect in the survival rates just as positively as they do for malignancy of the cervix. The average duration of symptoms has only improved slightly by the cancer educational campaign.

Other Causes of Bleeding

There are of course other explanations for postmenopausal bleeding than carcinoma. In a changing medical world, however, the old medical school axiom still holds that postmenopausal bleeding is due to carcinoma until proven otherwise. Too often

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the bleeding is explained on the basis of the presence of a polyp or senile vaginitis. Hypertension is known to produce uterine bleeding at this age.

Perhaps the most troublesome cause of postmenopausal bleeding other than carcinoma is that secondary to the use of the estrogenic hormone. It has become widely used for the treatment of hot flashes or simply to make women feel better. Bleeding occurs both as a result of prolonged administration or from withdrawal of the hormone. Therefore the physician falls into the trap of explaining the appearance of bleeding after the menopause on the use of the drug without considering the possibility that continued estrin stimulation may either mask or actually cause cancer of the endometrium. We know it may mask it. There is some evidence that it may cause it.

This is based on the repeated observation that granulosal cell carcinoma of the ovary or theca cell hyperplasia of the ovary may be associated with cancer of the fundus. These tumors secrete estrin continuously with resultant hyperplasia of the endometrium.

Estrin given parenterally or by mouth for hot flashes does the same thing. Not all women who take estrin will develop carcinoma of the endometrium but it is not too far a cry to suppose, given a proper substrate such as infertile uterus with an imperfect menstrual pattern, that continued estrin stimulation may be a part of the etiology of cancer of the endometrium.

Certainly too much estrin therapy is being prescribed for disorders of the menopause without first ruling out the possibility of an already preexisting carcinoma. In far too many instances the drug is prescribed without the benefit of a pelvic exam, much less a curettage.

It is of importance to break up the continuity in the administration of estrin for the symptoms of the menopause. The continuity of usage is more important than the size of the dose. The appearance of bleeding should be regarded as a danger signal and respected, not ignored.

Diagnostic Aids

The diagnostic aids in cancer of the fundus are not as effective as they are in cancer of the cervix. The chief reliance must be placed on diagnostic curettage.

Endometrial Biopsy

This is an office procedure carried out without anesthesia. The endometrial biopsy should not be regarded as a substitute for diagnostic curettage. A positive specimen is a definite finding but a negative report means only that no malignancy was discovered in that material.

Vaginal Smear

Again the vaginal smear is helpful but not conclusive. The reports have less accuracy than for carcinoma of the cervix. A diagnostic error of 26.5% was noted by Graham among 113 cases of cancer of the endometrium. This error would be materially reduced if the aspirations are carried out from the uterine cavity itself. The quoted figures are based on secretions from the vaginal pool. This method was chosen on the theory that some simple method should be devised that did not require special instruments or experience and could be easily taken by the general practitioner.

The same point of view should be extended to the vaginal smear that one employs in the biopsy reports. A positive smear should be regarded as significant, a negative finding means nothing.

Curettage

The primary diagnostic aid is a curettage under an anesthetic. The curettage should be methodical and complete. The procedure is not without its pitfalls for every surgeon has had the experience of missing a carcinoma lurking in the cornua of the uterus. A flat polypoid growth may also be overlooked when it occurs at the top of the fundus.

The diagnosis may often be made on the gross appearance of the curetted material which is usually white or colorless, crumbling, granular and hard. Where doubt exists it is better not to rely completely on the frozen section but to wait for the permanent paraffin sections. In this regard all curetted material, however small, should be saved for histological examination.

At the time of the curettage it is well to evaluate as far as possible the size and contour of the uterine cavity. This has a bearing on the subsequent application of radium. Not infrequently the uterine cavity is found to be distorted by the presence of a totally unsuspected submucous fibroid. It is well to keep in mind that the two not infrequently coexist and the curette may have difficulty in dislodging carcinoma which is hidden in the cornua above a submucous fibroid.

Where the final conclusion is reached that the tissue is benign it is important to regard any future bleeding as a violent danger signal calling for treatment at once. In too many instances such bleeding has been ignored because of the previous negative curettage, the more recent, the more dangerous.

Standard Treatment

The optimum treatment calls for the intrauterine application of radium at the time of the curettage in dosage of 3400 to 4500 mg. hours, followed in six weeks by a total hysterectomy with bilateral removal of the adnexae.

For the poor risk patient who cannot run the risk of abdominal surgery, radium alone is used in dosage from 6000 to 7000 mg. hours.

Preoperative Radiation

The reasons for the preoperative radiation revolve around the frequent appearance of vaginal and parametrial metastases following surgery where radium is not employed. These may appear because of implantation of tumor tissue at the time of surgery or as the result of lymphatic extension. Radium is given in the attempt to render the tumor cells non viable on the one hand and to block the lymphatics on the other.

Total Hysterectomy with Bilateral Salpingo-oophorectomy

The reason why total hysterectomy with removal of the adnexae is regarded as essential springs from a consideration of a natural spread of the disease. In the first place the disease may have spread from the fundus to involve the adnexae. This will happen in better than 10% of the cases. It is therefore important to remove the adnexae.

Furthermore cancer of the endometrium is a disease of the entire uterus, not just the fundus. The disease may be present in isolated spots within the uterine cavity or the entire cavity may be involved. Cancer may occupy both the cervix and the fundus by direct extension or lymphatic permeation.

Supravaginal Hysterectomy

It is obvious that supravaginal hysterectomy has no place in the treatment of this disease yet it is performed all too frequently. The chief reason, unbelievable as it may seem, is the failure to perform a diagnostic curettage. The rest of the blame may be traced to unfamiliarity with the operative technique, fear of an operative mortality or complete ignorance of the natural spread of the disease.

A further reason why the entire uterus should be removed including the cervix and wide cuff of the vagina is the nature of the lymphatic spread in the paravaginal tissue as an explanation of the frequent appearance of vaginal metastases.

Results

An attempt has been made to compile from the reports in the literature through 1948 end results from the use of surgery alone, surgery plus radium and radiation alone.

	Surgery Alone	*Surgery Plus Radiation* Various Combinations Surgery, Radium X-ray	*Radiation Alone* Radium Alone Radium plus X-ray
Total Cases	1384	1230	2387
5 yr. Salvage	63.7%	60.3%	38%

Because these patients are in the older age groups, intercurrent disease cuts into the five-year salvage. This is particularly true of cases where radium is employed for these are the poor risk patients.

Discussion of Treatment in Relation to Results

Radiation

The problem in radiation is that of delivering a cancerocidal dose in a blind cavity of varying size and contour to a tumor that can neither be seen nor felt and may be obscured by submucous fibroids or polyps.

It is small wonder then that uteri removed six weeks following radiation show residual tumor in 46-55% of cases examined routinely. Where serial sections are done the percentage is nearer 90%. It is impossible to determine, however, whether these cells are viable.

The observation immediately comes to mind that the figure for residual carcinoma parallels that for the salvage from the use of radium alone where the higher dosages of radium have been employed. Perhaps the sensitivity of the tumor or the resistance of the individual is more important than the actual dosage used.

Surgery

As regards surgery it certainly has been conclusively shown that supravaginal hysterectomy has no place in the treatment of the disease. By the same token some question may be raised as to whether the operation of total hysterectomy with removal of the adnexae can rightly be considered as adequate. Actually it is the same operation as carried out for a benign fibroid. It might well be argued that the operation to be adequate should remove wider sections of the parametrial and paravaginal tissue such as one might obtain by performing a Wertheim procedure. The possible spread to the regional nodes in the iliac and obturator areas would in turn call for a bilateral pelvic lymphadenectomy. Perhaps the morbidity and mortality of such a procedure would increase to the point where the five-year salvage would not be appreciably increased.

Summary

With continued experimentation in techniques of radium application to the uterine cavity, a more radical surgical attack following radiation and increasing propaganda to reduce the duration of symptoms and institute earlier treatment, increasing salvage may be anticipated in cancer of the endometrium.

THE DEGRADATION OF BRITISH MEDICINE UNDER SOCIALISM

CECIL PALMER

The Author. *Cecil Palmer, of London, England. Publisher, author, journalist, and signatory of the famous "Manifesto on British Liberty" issued by the Society of Individualists of which he is a leading spokesman.*

Earlier this year Cecil Palmer toured America to discuss before public audiences the dangers of socialism as he has witnessed its development in England. His address before the Conference of Presidents and Other Officers of State Medical Associations, at Atlantic City in June, was published in our Journal in September. Mr. Palmer has now submitted the following article outlining his observations following his return to England last summer.

The Editors

SOMETIMES during my recent coast to coast speaking tour throughout the United States, when dealing on platform and on radio with the subject of socialised British medicine, I have asked myself the questions: Am I over-stating the case against a State Medical Service? Is it, in fact, as bad as I am painting it? Is it, in short, a step backwards in the grand and centuries' old history of a noble, progressive and learned profession? I have now returned for a brief space to my native land, and, in the lucid intervals snatched from day to day topical journalism, I have been at pains to find *objectively* the right answers to my politically right-wing questions. I now do not hesitate to state that socialised medicine in Britain is a national disaster. With equal emphasis I would humbly and sincerely ask the great American public and its fine medical practitioners to think once and twice and thrice before they commit the folly and the sin of throwing away the freedoms of medicine for the tyrannies and palpable inefficiencies of a so-called National Health Service. Whatever little excuse there may be for Britain's "sell-out" to the politicians, there is surely no excuse whatsoever for America copying such a self-evidently bad example.

Theoretically, our British scheme was the cutest political I.O.U. ever dangled before the noses of a wishful-thinking public. In practice, it is an outsize in perpetual headaches for a disillusioned public and for an overworked, underpaid and frustrated profession. The evidence, both from doctor and patient, in support of this admittedly scathing indictment is as overwhelming as it is alarming. Fortunately, the British medical profession itself and its erstwhile trusting victims, the general public, are alike coming to the conclusion that socialised medicine, like most other quack remedies, is admirable until it is submitted to the test of practical experience. Personally, I will always find it had to forgive the doctors in my country who, as is now quite plain, sold themselves and their patients out of liberty and into slavery. For to-day, in Britain, neither state doctor nor his patient is a free citizen. Both are under compulsion to do or not to do what a state bureaucracy determines under an Act of Parliament which embodies in spirit and letter the two wicked totalitarian assumptions that "It is the *duty* of the citizen to keep well" and that "It is the *duty* of the doctor to exercise *harsh* certification."

It is now approximately fourteen months since most of the people in Britain deceived themselves into believing that socialised medicine would herald the dawn of a medical Utopia and that, above all, it would be FREE. They now know that a state salaried medical service has produced no more doctors, or nurses, or hospital beds, or, indeed, no more facilities or amenities of any kind. The result is that there are now infinitely more people competing for the same amount of service for the very good reason that people who formerly were willing and able to pay for it, now, as *compulsory* contributors, seek it under the state scheme. A well-known consultant has placed on record that "before the scheme started on July 5, 1948, a general practitioner requiring my opinion upon a working-class patient could get an appointment for him to see me at my out-patient clinic at the hospital that same week. Under the state scheme, my clinics (and those of all my colleagues) are overflowing. so that a patient has to wait as long as a month for an appointment." The same authority has also pointed out that under private medical practice all the public wards in the hospitals were devoted to patients of low income groups. To-day these people have to share the same number of beds with people

who could, and did, but who now probably cannot, afford private accommodation. Inevitably, therefore, the sick poor who were supposed to be preferential beneficiaries under the state scheme have to wait weeks and sometimes months for admission to a hospital. In General Practice, where patients are expected to attend their doctors' surgeries or "offices," long queues are inevitable because even so trifling a function as obtaining an extra allocation of milk requires form-filling and certification. Britain is in real danger of becoming a nation of petty hypochondriacs—petty in the sense that patients now pester the doctor concerning trivial ailments which hitherto have been adequately treated at home. The menace is that really ill people are swept aside in the mob rush for medical treatment, and this serious and cruel situation is every day becoming more acute.

In a medical service which with much government-sponsored ballyhoo was launched with the fantastic assurance that it was free, it is not surprising that the politically unsophisticated majority in the British community placed complete confidence in the implementation of political promises. It was to be free, so why not enjoy bad health while the medical going is good and gratuitous. Alas, the accounts are now coming in with alarming financial implications for a self-confessed bankrupt country. The Socialist Government has been forced by events to order an official enquiry into sick pay claims which all over the country have registered appalling figures. In the first year only of the National Insurance Scheme there were *seven million* claims for sickness benefit. They rose to a peak of 220,000 in a single week in the second month of this year, and, today, they average not less than 100,000 a week. In the Royal Ordnance factories (which are, of course, state-owned and state-controlled) sickness benefit claims have increased by roughly 20 per cent since July 1948. The length of time workers are absent from their jobs has risen also. The explanation of this state of affairs is ridiculously simple. In these soft-cushioned state factories the workers not only receive the statutory sick benefits, but to these sick benefits are added sums equal to the difference between the sick benefits and *full wages*. This "privilege" is extended to each Ordnance worker for a period of 13 weeks. For another 13 weeks sick benefits are made up to half wages. In addition, many of these workers draw extra benefits from privately-run "Sick Clubs," *so that when absent sick they are actually better off financially than when working*. Worse still is the fact—frankly admitted by the Minister of Health—that "thousands of workpeople are *fraudulently* drawing sick pay benefits." The socialist dishonest gospel of "something for nothing" is producing a moral and financial problem, the solution of which is unthinkable in terms of Marxian materialism. In a word, the present socialist government in Britain has released immoral and economically disruptive forces which it will find are increasingly difficult to control, and ultimately impossible to suppress.

If, as I hold, it be true that we in Britain can save ourselves primarily only by cutting our coat according to *our* cloth, I hold it is equally true that high priority in drastic cutting of governmental expenditure must be given to those things which in a so-called welfare state give so little in service and cost so much in taxation, both direct and indirect. Meantime the medical profession at least is fortunate beyond its deserts. *It has a leader* if it will but listen to him. In Lord Horder all that is great and glorious in the immemorial history of British medicine has a spokesman, a fighter and a defender. It seems to me (and I humbly submit the thought for American consumption) that the mere fact that under socialised medicine in Britain to-day a new and vigorous organisation has come into existence to protect by fellowship and unity the freedoms in medicine is, in itself, at once an indictment and a salvation. "Once you get," Lord Dawson of Penn predicted, "medicine and its science and art under the control of the Civil Service, good-bye to the best in medicine!" This prophesy has fulfilled itself with distressing prescience. What is actually happening under socialised medicine is, as one distinguished doctor has summarised, that "the medical profession is being converted into a machine for the production of medical statistics to be used in political speeches, and the patient is becoming little more than a name on a form."

Last June I had the great honour of addressing the Conference of Presidents and Other Officers of State Medical Associations at its Convention in Atlantic City. I was then encouraged to believe that most American doctors see quite clearly that a State Medical Service, despite all political protestations of goodwill and equity, cannot fail to degrade a great calling and an honourable vocation which, first and last, lives and has its being in the voluntary spirit. It does not lend itself to regimentation, standardisation and mass production. It is art and science and, quintessentially, it is God's work. The socialist state has no place for God and no reward for work. In my beloved country, I am happy to reveal, there are growing signs of "divine discontent." In all walks of life, among the young, the old and the middle-aged, is to be found an awareness that what Sir Ernest Benn so aptly called the "Political Method" contains within itself the seeds of its own destruction. With eager feeding, the totalitarians are choking themselves. The lesson from British socialised medicine for America is crystal clear. We in Britain have had a bitter taste

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ANESTHESIA IN CARDIAC ARRHYTHMIAS AND CONDUCTION DISTURBANCES

EDWARD DAMARJIAN, M.D.

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CARDIAC ARRHYTHMIAS are an important part of anesthesia and the anesthesiologist should familiarize himself with their diagnoses, evaluation and treatment.

A. Disturbances of Pacemaker (Sino-auricular node)
   1. Sinus tachycardia
   2. Normal Bradycardia (below 60)
   3. Sinus Arrhythmia
   4. Sinus Pauses (skipped beat)

B. Ectopic Rhythms
   1. Premature Auricular beats (no compensatory pause)
   2. Paroxysmal Auricular Tachycardia (rate approx. 220)
   3. Auricular Flutter (rate 200-360)
   4. Auricular Fibrillation (rate 400 plus)
   5. Ectopic Nodal beats
   6. Ectopic Ventricular beats (compensatory pause)
   7. Paroxysmal Ventricular tachycardia (rate 160-200)
   8. Ventricular fibrillation

C. Disturbances in Conduction
   1. Delayed Conduction time (P-R interval over .2 sec.)
   2. Partial Heart Block
   3. Complete Heart Block (rate approx. 40)
   4. Intraventricular Block (QRS over .1 sec.)
   5. Bundle Branch Block (QRS over .12 sec.)

D. Ventricular Complex Disturbance
   1. Digitalis Intoxication (Coupling, Block, S-T sagging)
   2. Myocardial Infarction

E. Fundamental Knowledge of Electrocardiography

A. Disturbances of Pacemaker

Normal tachycardia is a mild form of increased heart rate due to exercise, emotion, fever or thyroid stimulation. Normal bradycardia is a slow rate occurring in tall athletes or occasionally in jaundiced patients. Sinus arrhythmias are normal waxing and waning of the heart rate associated with inspiration and expiration. Sinus Pause is a dropped beat which has been reflexly inhibited, probably through a Carotid Sinus effect. None of the above disturbances are serious and would have no effect on the type of anesthesia used.

B. Ectopic Rhythms

A premature auricular beat arises in the auricular musculature and is of no consequence unless it occurs in the presence of mitral stenosis. Then it may be a forerunner to an impending auricular fibrillation. The diagnosis is best made by E. K. G. (although it has no compensatory pause, it is difficult to ascertain clinically). Paroxysmal Auricular Tachycardia is a definite entity. It is not serious and usually can be stopped by pressure over the Carotid Sinus or pressure on the eyeballs. Clinically the diagnosis is made by its rate and the abruptness with which it starts and the spontaneous return to normal rhythm. Auricular Flutter may or may not be of serious consequence depending on its cause. At times it may be purely functional. On the other hand, it may be a transient stage of auricular fibrillation. The diagnosis is frequently overlooked because the radial beat will be regular and normal; but the jugular pulsations in the neck may have a rate 2 or 3 times that of the radial beat (thus a 2:1 or 3:1 flutter). Auricular fibrillation is the highest degree of auricular disturbance and is of serious concern to the anesthesiologist only if the patient is not well compensated. A long standing auricular fibrillation or a fibrillating patient that is digitalized is of no particular worry to the anesthesiologist. On the other hand, a recent fibrillator may suddenly go into decompensation if subjected to anesthesia due to increased tax on a heart that has not had a chance to acclimate itself. The treatment of flutter and fibrillation is quinidine and/or digitalis. Nodal extra-systoles are abnormal beats that arise in the Bundle of His and Ventricular extra-systoles are ones that arise in the musculature of the ventricle. Neither are of special concern except if they occur too frequently. You will note that the

rate of ventricular tachycardia is often slower than auricular tachycardia. The treatment is quinidine. The rate should return to normal before administration of Anesthesia; and Cyclopropane will surely precipitate another more serious attack. Cyclopropane with any type of ventricular extrasystoles should be avoided. It should not be administered to patients in the presence of Adrenalin or Ephedrine because Cyclopropane sensitizes the automatic tissues of the heart to sympatheti o-mimetic drugs and may result in ventricular fibrillation. Pituitrin is also incompatible with Cyclopropane and Pitocin can be used instead. Ventricular fibrillation is not compatible with life. Such fibrillation may last from 3 to 5 minutes and unless the neuromuscular mechanism is made less irritable by procain-like drugs or manual massage, it will cease to function. In such cases Procain, either intravenous or intra cardiac will make the myocardium less irritable and may shift the pacemaker from the ventricle or A-V node back to the S-A node. Diagnosis can only be made by E. K. G. Recently Dibenamine has been used with considerable success to inhibit the Sympathetico mimetic action of adrenalin.

Conduction disturbances are all relative, going from a mild form of a prolonged P-R interval to a complete block where the auricles and ventricles beat independently. These disturbances are not contra-indications to any form of anesthesia unless the block is of recent origin. A prolonged P-R interval in a child is the cardiologist's spectacular spot diagnosis of Acute Rheumatic fever. Then again digitalis intoxication can cause any one of these degrees of block. Merely stopping the digitalis will gradually eliminate the block. The Cardiologist's trick of making a diagnosis of complete heart block on a suspiciously slow pulse rate is to note if, on auscultation, the first heart sound varies in intensity, being at times muffled, accentuated or reduplicated (split beat). Furthermore the auricular beats in the neck will not synchronize with the radial pulse. Otherwise the diagnosis is made by E. K. G. The treatment is to eliminate the cause (digitalis) if possible. On the other hand if such a block makes a patient decompensated, he may be given digitalis to compensate. Here again, anesthesia is not definitely harmful except in the decompensated patient who will not stand the extra load put on the already overburdened heart. Cyclopropane with its parasympathetico-mimetic action may cause a partial heart block to become complete, or a complete heart block to become a Cardiac standstill. It therefore should not be used. On the other hand, a chronic complete heart block may go on beating for years and the use of Atropine or Adrenalin is not contra-indicated but, on the contrary, it is part of the treatment if a patient shows signs of syncope from too slow a ventricular beat.

Intra-ventricular block is a mild form of Bundle Branch Block. Both are signs of chronic myocardial damage but not enough to be influenced by any anesthesia which doesn't give anoxia to the myocardium during administration. Cyclopropane has been given to such patients without ill-effect but should not be encouraged. On the other hand, if Bundle Branch Block has been caused by either digitalis or a recent Coronary Thrombosis, then anesthesia should be delayed, especially so for the latter.

Myocardial infarction of recent origin is a contra-indication to general anesthesia. A reasonable delay, if such is possible, will make a considerable improvement in the area of myocardial ischemia. Digitalis intoxication can be easily treated by its omission for a period of time and recheck by E. K. G. for optimum time for anesthesia. Coupled rhythm is characteristic evidence of digitalis intoxication. On the other hand a chronic myocardial degeneration will cause coupled rhythm and this is of no definite consequence as far as type of anesthesia is concerned. However, coupled rhythm should not be confused with Pulsus Alternans where each weak beat is followed by a strong beat the rhythm being regular. This has a guarded prognosis and is indicative of serious cardiac disease.

Electrocardiography

The anesthesiologist should become acquainted with the common types of serious E. K. G. changes so that he may be prepared in cases of emergency to make a preliminary diagnosis pending the arrival of a cardiologist. On the other hand an anesthesiologist should not feel competent enough to take issue with a single E. K. G. tracing, because the Cardiologist is frequently basing his expert opinion on a series of tracings showing progressive changes.

One should recognize a prolonged P-R interval (over .2 sec.) present in Acute Rheumatic Fever. Prolonged QRS complexes (over .12 sec.) shows presence of Bundle Branch Block. He should recognize P waves in a tracing so that their absence would signify auricular fibrillation. He should recognize altered S-T intervals. Sagging S-T intervals suggest digitalis intoxication. If they are all elevated concurrently then Pericarditis is suspected. The first E. K. G. changes in myocardial infarction may be changes (either elevation or depression) of S-T intervals. The site of infarction, either anterior or posterior, is usually determined by the combination of the leads involved.

Conclusion

The anesthesiologist should note any progressive or new cardiac signs either clinically or evidenced by E. K. G. changes that a patient may show. It is these unstabilized hearts which may give trouble during an anesthesia. On the other hand, a compen-

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sated heart that has had the same arrhythmia for years is of little consequence and can handle the extra work that you may assign to it. Any myocardial irritant-anesthetic like Cyclopropane should not be used in presence of ventricular irritability. Pre-operative medication is also important. Patients that are fibrillating (auricular) and are compensated either with or without digitalis should not receive cardiac stimulants or accelerators because of the danger of decompensating an already good working myocardium. A heart that suddenly becomes decompensated during or after an anesthetic should be digitalized rapidly. Atropine in normal doses, will not alter the rate of a fully digitalized heart. Evidences of acute digitalis intoxication may be noted on pre-anesthetic examination. Such signs as coupling, markedly sagging S-T intervals, or Delayed Conduction time by E. K. G. is highly suggestive of digitalis poisoning and operation should be delayed.

Cardiac standstill is very important. One must determine if the standstill was due to vagal overactivity or whether the heart is in ventricular fibrillation. A sudden stoppage of the heart should suggest vagal activity. On the other hand the heart that has stopped because of ventricular fibrillation may possibly show evidences first of multiple ventricular extrasystoles or ventricular tachycardia before precipitating into fibrillation. In case of vagal standstill, the treatment is intra-cardiac adrenalin into right side, preferably into right auricle, and then cardiac massage. On the other hand a heart that is in ventricular fibrillation should not get adrenalin but rather intra-cardiac procain followed by cardiac massage or electrical stimulation. If in doubt do not give adrenalin by any route. Cardiac massage through the opened chest is the most surely effective procedure.

If a heart shows evidence of a rapid rate but also is regular, then there are only three possibilities: 1) Normal Tachycardia, 2) Auricular flutter, 3) Paroxysmal Tachycardia. The diagnosis of each can be made clinically. The slightly irregular rhythm of ventricular tachycardia is frequently hard to detect and differentiate. Clinically it may appear to be rapid and regular. Positive differentiation can be made by E. K. G. If a patient develops a rapid irregular rhythm during the course of an anesthesia, the anesthesiologist must determine whether this patient has developed auricular fibrillation or possibly is approaching a fatal ventricular fibrillation. The decision is often difficult without an E. K. G.

Spinal anesthesia can be given arrhythmic patients if one anticipates any drop in blood pressure by supplying adequate treatment. Routine use of Ephedrine in these patients should be discouraged. If necessary to sustain a falling blood pressure, very small doses of Neosynephrine may be given. Patients on the verge of decompensation would do better with inhalation rather than a high spinal anesthesia because a severe drop in blood pressure may reflexly cause an acceleration of the heart rate —a rate that a fibrillating heart could not tolerate. In many instances, choice of anesthesia depends on the ability of the anesthesiologist.

Morphine should not be of any particular concern to the anesthesiologist in these cases. Cardiologists give it freely to reduce the dyspnea of acute decompensation.

TREATMENT IN PSORIASIS

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ships to carry out this treatment which not only requires a troublesome dosage, but unpleasant gastro-intestinal disturbances. One patient out of seven who were given the minimum treatment of three months responded well. (Dr. Perlman received thirty per cent improvement in his cases.) The most I can say is that in cases of patients with emotional difficulty when confronted with Psoriasis, this type of medication can be of some help. In conclusion I should like to remind doctors interested in working with this newest drug for Psoriasis, that it is but another step in the trial-and-error-process of discovering a cure for this condition.

"In a disease with a cause as unpredictable as that of Psoriasis and in one so capable of spontaneous remissions or favorable responses to any new approach at any time, attempts to evaluate a new therapeutic method may easily lead to erroneous impressions."[3]

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[2] *Ibid,* Report on the Undecylenic Acid Treatment in Psoriasis, Perlman, Henry, February 1949.

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BRITISH MEDICINE UNDER SOCIALISM

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of it. And how bitter I would crave the editor's sanction to elaborate on some future occasion. If Americans, lay or professional, imagine for a moment that what has happened elsewhere cannot happen at home, I beg them to remember that that is exactly what nine Englishmen out of every ten imagined and believed only a comparatively few months ago. An ancient Chinese philosopher warned us in vain that "It is later than you think."

The RHODE ISLAND MEDICAL JOURNAL

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DIETARY DISCREPANCIES

The kitchen is a good apothecaries shop.

WILLIAM BULLEIN, 1562

While the influence of diet upon health has been recognized since the time of Hippocrates, and probably earlier, it was not until the end of the nineteenth and the early part of the present century that the discovery of new food factors, improved and simpler methods of estimating basal metabolism, and rapidly increasing knowledge of the chemical composition of foods, brought the subject of dietetics once more into the limelight—for, like other subjects in Medicine, progress in our knowledge of nutrition has been cyclic. The discovery that not only the well-known food factors; fats, carbohydrates and proteins, were essential, but that certain minerals and the accessory food factors known as vitamins were necessary, is comparatively recent and, during the present century, knowledge of these substances has been constantly increasing and changing, so that we are again in a condition of flux with more or less confusion as to what constitutes a normal diet. This, as will later be discussed, is apparent from even a superficial perusal of the current literature.

As always, a period of uncertainty such as this, partly due to a lack of correlation and clarification of the mass of newly-acquired facts, has provided a rich field for exploitation by food faddists and dietetic quacks. Some of these individuals, particularly those practicing medicine, are honest but badly-balanced and deluded, while others are mere charlatans taking advantage of the fact that the public, particularly its feminine portion, is food conscious. Some of the dietary regimens introduced by members of the crackpot group, who might be described as the lunatic fringe of dietetics, are relatively harmless. However, this is by no means always the case. An example in point is the advocacy of raw versus pasteurized milk by persons who seem to have forgotten that brucellosis, septic sore throat, tuberculosis, typhoid fever, scarlet fever, and occasionally diphtheria and other infections, may be transmitted by raw milk. Even that new disease, Q Fever, is suspect, for its causal rickettsia has been isolated from raw milk by Huebner.

It is evident from the literature that some experienced and well-balanced physicians have been casting doubt on the validity of some currently accepted dietary beliefs. As example may be noted articles such as that of Soper stressing the importance of high protein diets, especially, early in the work day, in contrast to Chittenden's conclusions of the early part of the century that we were consuming too much protein. Then there are the views of the Swiss Federal Commission for Nutrition which indicated, according to Fleisch, that we eat too much, and that the United Nations' minimum standard of 2400 calories a day is too high. This opinion is based on a large scale experiment with four million Swiss citizens. On the other hand, nutritional studies of French origin show that the inhabitants of the rich rural districts whose daily ration amounts to 3000 calories are much healthier

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than those of the Mediterranean region where the daily caloric intake is only 1500 calories. In the latter area the death rate is fifty per cent higher than it was in 1936-38, and even in Paris and Lyons, where the caloric intake is higher than this, the death rate in children under 4 and adults over 70 has increased twenty to thirty per cent, whereas in the food-rich rural districts the death rate, especially from tuberculosis, has declined ten to twenty per cent. In France too, Madame Raudoin of the National Academy of Medicine has shown the importance of unbalanced diets in children in causing stunting in size and delay in the onset of puberty. Saidman has shown the effect of such diets on thermogenesis, the fall in surface temperature which results being probably a protective mechanism to diminish caloric loss. Mayer has pointed to the serious defects in glucides, fats and milk in many French diets.

These observations, and many comparable ones that could be cited, indicate that both quantitatively and qualitatively the question of the ideal diet is still not conclusively decided. As Walter Alvarez has suggested we have probably not paid sufficient attention to nor adequately studied the dietary habits of alien peoples, many of whom flourish on diets that we would consider bizarre and outlandish. As Amundsen has shown, the Esquimaux flourish on a diet very high in protein and fat. But we know comparatively little, scientifically speaking, of the diets of many Oriental peoples: the Chinese, the Japanese, the inhabitants of India, Burma, and Polynesia. It is obvious that much study of food and nutrition is still needed before we are on solid ground as regards many aspects of this vital subject. Nor need we be too much disturbed because the American public is at present suffering from vitamania and is being subjected to a barrage of dietetic misinformation by half-baked and poorly-balanced enthusiasts. In time such situations become adjusted. G.B.

TEAMWORK

A century or so ago Dr. Holmes expressed the feeling that the appearance on the medical scene of Homeopathy had undoubtedly done good by tending to check the tremendous overtreatment going on in those days. It seems wise to say that treatment is employed on a much larger scale now than in Dr. Holmes' time. Our argument does not concern itself with the efficacy of modern treatment but with the economics. Present day agents are nearly all expensive. This is an era of spending and nowhere is it more noticeable than in therapeutics.

A 90-year-old woman with a hemiplegia recently entered the hospital. She was immediately put on penicillin whose cost is still not negligible. Although she could swallow and was well nourished on arrival she immediately got intravenous fluids. As she had been living at the Providence Biltmore its well-balanced diet offered no suggestion of a vitamin deficiency but she immediately got these. Some of them are expensive. Add to this one of the more expensive heart medicines although her heart still seemed to be efficient after 90 years of use. Then, presumably for diagnostic purposes, several expensive laboratory procedures were done although we fail to see how they would modify the treatment. We are not criticising any one of these procedures; we are just emphasizing that they aggregate considerable expense.

We have just heard from the parents of a young girl who has recently entered college with a health certificate with some two dozen different items filled out for her. She is a fine young physical specimen but she says that the college authorities are making life miserable for her because the space labeled blood count has been left blank. If every college student in the country has a blood count at reasonable laboratory prices the finances involved are enormous.

Within a few years one of the major firms of the country has developed and publicized a substitute for morphia. This is an expensive preparation. You will listen a long while to reports of cases before you will hear that morphia was given rather than this new drug.

Codeine is continually being given for pain although it has exceedingly small if any value in such cases and it is expensive.

All these expensive procedures should deserve careful consideration from doctors. The price of medical treatment is being stressed to the public. It does not seem possible that such a wave of therapeutic and diagnostic spending can be financed without government aid. The laws of diminishing returns, the balance of results against effort, and financial consideration, all are arguments against our present procedures.

Enthusiastic physicians are working in this respect hand and glove with Oscar Ewing to bring about government control of medicine.

BE A PARTICIPATING PHYSICIAN

This month every doctor of medicine has been mailed a brochure outlining in detail the surgical-medical insurance plan to be operated by the Rhode Island Medical Society Physicians Service in cooperation with the Hospital Service Corporation of Rhode Island.

The surgical phase of this new program duplicates the present Rhode Island Plan in operation under the Society's auspices and underwritten through private insurance companies. This Plan continues, and it has the support of the majority of the physicians who have signed as participating physicians for the persons in the eligible income groups.

Now every physician is asked to sign as a participating physician for Physicians Service—the Society's own program. This new plan should receive one hundred per cent support of our membership. It is the type of plan that has proved successful throughout the country, and it will be controlled and supervised by the medical profession to the best advantage of the public.

It is YOUR plan. Your immediate duty, therefore, is to sign and return the Participating Physicians agreement that has been sent to you. Your second major responsibility is to assist in every way towards the successful adoption of prepaid voluntary insurance by the people of Rhode Island.

COOPERATION DESIRED BY PUBLIC RELATIONS COMMITTEES FROM THE STATE SOCIETY AND THE AMA HEADQUARTERS*

CHARLES L. FARRELL, M.D.

Chairman of Committee on Public Policy and Relations of The Rhode Island Medical Society

OUR COMMITTEE on Public Policy and Relations is composed of alert and aggressive physicians who are willing to make, and who do make, considerable sacrifice of time and energy in fulfilling committee objectives. We do not have a Public Relations Director and therefore the committee chairman and the executive secretary of the state society have to be ready to collaborate at a moment's notice when stories break in the press.

This poses the first problem for any Public Relations Committee. How much power has the committee—has it the authority to speak for the profession, or is someone to be the official spokesman? In choosing a spokesman it is imperative that he at all times be so completely informed, and so accurately posted, that his facts cannot be disputed—and most important that he have the confidence of the profession. He must also be acutely aware of all shades of opinion within the profession and to evaluate correctly the type of public statement that will reflect credit on the profession and clarify its stand on public matters to the satisfaction of all factions and shades of opinion within the medical society. He must often gamble and risk criticism if he knows that he can fully substantiate his stand before the official officers of the Society. The Society is hurt, and public relations will suffer, if even an occasional whitewash or half-hearted support has to be offered to a spokesman who errs.

Therefore, Public Relations Committees should expect the State Society to provide a well informed and universally acceptable spokesman, who can, at a moment's notice present the medical profession's viewpoint with due consideration for the public interest. He should either be a paid public relations counsel or the physician chairman of the committee.

The next problem of any public relations committee is money. How much can it get and how best to spend it. In Rhode Island that is no problem for we have no appropriation and spend no money. If we have a project that is meritorious we can present it to the President and members of the Council and usually get sufficient funds for that occasion. Our Executive office will handle mailing, stenographic services, mimeographing, and so forth, and will pay for telephone and telegraph charges incurred by the committee in conducting its affairs. This proves satisfactory in Rhode Island but I can conceive of the definite need of an appropriation for the unrestricted use of the committee. It should wherever possible use the existing state society facilities but it should also be able to engage its own if conditions warrant.

It is important also that the State Society have sufficient confidence in its public relations committee to permit them to act for the society without red tape. The committee should know what constitutes good medical practice and what actions would, or would not, be approved of by the profession. They should therefore be able to speak promptly and clearly for the profession without having to go through the Council or the House of Delegates for official opinion regarding newly arisen situations on which no official stand has been taken.

Public Relations Committees should also expect the state society to permit its members close contact with and attendance at all meetings of the Council, House of Delegates, Blue Shield meetings, and any other activities with which it has no official connection.

Public Relations Committees in many states produce news letters, bulletins or periodic reports for all members of the profession, thus acquainting them with the "behind-scenes" activities of the medical society. We believe the most effective form is one which reaches the doctor directly through his personal mail rather than a supplement to, or a part of, official publications. The brief, pithy comments of the direct mail release can oftentimes contain confidential or semi-confidential reports that have to be omitted from official publications.

State societies should publish informative booklets designed to educate the profession at large to the problems confronting medicine and the means employed to meet them. The profession would thus present a more united front to all issues if all the facts were placed before the whole profession in such a manner as to clearly define the issues. We usually agree on the diagnosis if we have all the

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*Abstracted from address presented at the 2nd National Public Relations Conference sponsored by the American Medical Association, at Chicago, November 5, 1949.

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data and it is properly presented. Under such circumstances our treatment is usually similar.

A speakers' bureau is imperative but speakers on medical subjects need indoctrination. We offer an instruction course and various literature designed to acquaint the profession with the pros and cons of socialized medicine. We send speakers to all who will listen and we write to all groups who plan meetings and request permission to address them.

It is extremely important, however, that we prepare our speakers well beforehand and make sure that they will not be tricked into unfortunate statements or display ignorance of any phase of the subject under discussion. It is preferable that material for speeches be carefully scrutinized in advance and that the speaker be well versed in snappy repartee so as to be able to give as well as take in any discussion that ensues. Too often have we learned that in every audience there is always someone who is primed to disagree violently with what we have to offer.

In summary then we expect the state society to supply:

1. An able chairman, alert and willing committee members.
2. A spokesman who will either be a public relations counsel, some official of the society, or the chairman of the public relations committee, who will be available at all times and ready to meet emergencies.
3. Sufficient money and clerical help as well as access to existing county or state society executive offices.
4. Broad powers to act in an emergency and opportunity for consultation with top officials and other committee chairmen.
5. Freedom to deal with the public relations problem without red tape and specific authorization.
6. Liaison with Blue Cross, Blue Shield, Council and the House of Delegates, Department of Labor, Unemployment Security, Cash Sickness, and the like.
7. Print or supply material for use by the press, radio stations, bulletins to the general membership and material for indoctrinating speakers.
8. Copies of reports from other committees, notices of their proposed activities so that the public relations committee can integrate its work with theirs. For example the "Diabetes Detection Week" publicity though stemming from the committee on Diabetes should be developed in collaboration with the Public Relations Committee.
9. Aid in the development of a speakers bureau.
10. Last but by no means least, representatives from the ladies' Auxiliary to the Public Relations Committee, and vice versa.

From the AMA we desire a greater quantity of press releases. We have no fault to find with the type we have been receiving but too often we are in a quandary as to whether we are to release it or to wait for releases from headquarters. It is necessary for us to have sufficient quantity of all press releases so that they may be sent to all newspapers in the area. It is impractical and time consuming for us to have to reproduce this material. In many instances it would be better to send such material to the district societies as well as to the state chairman. Frequently the local committee has a better opportunity to get material in the home town paper than some higher official.

Secondly we need short, snappy articles for use in small town weeklies. Very often the weekly newspaper welcomes such material and it helps to fill space. It is imperative, however, that such material have punch lines or highlight some development or action of interest to everyone.

Third we desire more direct mail to special groups and we can furnish the lists, for example, the profession has been pretty well circularized and fairly well indoctrinated but the lawyers, the teachers, and the chambers of commerce offer virgin territory for direct contact. The chamber of commerce of the United States published and distributed a booklet entitled "You and Socialized Medicine". The local chambers of commerce distributed these among the business men of the community and evoked considerable interest.

Fourth we would like faster news regarding congressional activity. We appreciate that it is necessary for the Washington office to clear through channels and to get official attitudes developed at headquarters. We suggest, however, that all actions of Congress or its committees be officially scrutinized and evaluated and that the attitude of the AMA be determined as expeditiously as possible. Following this, telegraphic or fast mail communications be sent to states and district societies, including specific requests for any action desired so that our public relations committees can muster their forces immediately.

Fifth the P.R. Doctor and Exchange is very good and we provided all our district societies presidents and secretaries with copies of the booklet prepared by California in order to acquaint them with the responsibilities of their office. We have found many other helpful suggestions and ideas

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PUBLIC RELATIONS COMMITTEES

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and suggest that they be given even wider distribution to include county society committees.

Sixth we feel that this national conference held annually is extremely important and it should be continued, but we believe a regional conference is of even greater importance because many physicians who are interested in public relations will travel a short distance to attend a regional conference but will not go to the expense and bother of attending a national conference at a great distance from home.

Seventh we suggest representatives from the AMA visit the smaller groups following the regional conferences and help develop the proper evaluation of public relations at the local level. It is a well-known fact that most physicians know very little concerning the subject of medical economics, and they need to be instructed by outsiders rather than their own professional brethren.

Finally it would be of considerable help if the releases from the Washington office would be sent to the district public relations committees as well as the state.

I fully appreciate that the problems of the different states differ considerably and I hope that the ensuing discussion will develop many points that I have failed to cover. I do not presume to claim that our solutions are the best ones and I will have obtained my objective if I merely bring forth ideas that we all can use.

HOUSE OF DELEGATES OF THE RHODE ISLAND MEDICAL SOCIETY

Report of Special Meeting, November 8, 1949

A SPECIAL MEETING of the House of Delegates of the Rhode Island Medical Society was held at the Medical Library on Tuesday, November 8, 1949. The meeting was called to order by the President, Dr. Peter Pineo Chase, at 8:45 p.m. The following were in attendance:

Kent
Peter Erinakes

Newport
Louis E. Burns

Pawtucket
Earl Mara
Henry Hanley

Washington
Juliana Tatum

Woonsocket
Henri Gauthier
Victor Monti

Providence
Philip Batchelder
Frank B. Cutts
William P. Davis
John Dillon
William J. H. Fischer
David Freedman
Herman P. Grossman
William Horan
Robert G. Murphy
Michael O'Connor
Alfred L. Potter
Louis A. Sage
Daniel V. Troppoli
George W. Waterman

Officers
Peter Pineo Chase
Charles J. Ashworth
Morgan Cutts
G. Raymond Fox

Midwinter Meeting at Newport

Dr. Peter Pineo Chase reported on the plans of the Committee on Scientific Work and Annual Meeting for the midwinter meeting of the Society to be held at Newport on Wednesday, December 14, 1949.

Report from Rhode Island Medical Society Physicians Service

In the absence of Dr. Joseph C. O'Connell, Dr. Charles J. Ashworth briefly reviewed the meetings of the officers of the Society with officers of the Blue Cross and he related the final agreement signed by Drs. Joseph C. O'Connell and Morgan Cutts as president and secretary, respectively, of the Society's Physicians Service with the Blue Cross for the merchandising of the Surgical Insurance.

Dr. Ashworth also pointed out the changes that had been made in the joint agreement from the one submitted to the House of Delegates in September. There was brief discussion of the matter after which Dr. Herman P. Grossman moved that the House of Delegates approve of the action taken by the officers and approve of the signing of the agreement between Rhode Island Medical Society Physicians Service with the Hospital Service Corporation (Blue Cross) of Rhode Island. Dr. G. Raymond Fox, Treasurer, moved that the House of Delegates appropriate the sum of $2,000, plus legal and other organization expenses as a loan to the Rhode Island Medical Society Physicians Service, said loan to be repaid to the Society as soon as Physicians Service is in a position to do so. The motion was seconded and adopted.

Medical Benefits

Dr. Morgan Cutts discussed the possibility of including Medical Benefits in the surgical plan at its very start. He cited the advantages to be gained by including such a provision in the contract and he proposed the inclusion of the following section in the surgical agreement:

(f) Medical Services (except as provided in Part III below) when rendered by a physician to a subscriber ONLY WHILE A BED PATIENT IN A HOSPITAL, and only if no surgical services are performed during the same continuous period of disability. Payment will be made at the rate of $3.00 for each day from and after the fourth (4th) day of each hospital stay, not to exceed thirty (30) days for any one hospital admission. Any admission to the same or any other hospital for the same or related cause, occurring within ninety (90) days of the date of discharge of a previous admission for such cause shall be considered to be the same admission. In computing the number of days the day of admission shall be counted but not the day of discharge.

There was discussion of the proposal after which Dr. Daniel V. Troppoli moved that the House of Delegates approve of the adoption by the Rhode Island Medical Society Physicians Service of the medical provision to be added to the surgical contract. The motion was seconded and adopted.

The Rhode Island Plan

Dr. Charles L. Farrell briefly discussed the position of the Society as regards the Rhode Island Plan which utilizes the commercial insurance companies. He reported that the Health Insurance Committee did not feel that this plan should be terminated at this time merely because the Rhode Island Medical Society Physicians Service had been activated.

Dr. Farrell also reviewed the investigations

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DISTRICT MEDICAL SOCIETY MEETINGS

PROVIDENCE MEDICAL ASSOCIATION

On petition from members of the Association a special meeting was called for September 27. There was an attendance of 162 at this meeting.

The purpose of the meeting was to conduct an open discussion of the Medical Society-Blue Cross controversy regarding the surgical insurance program. Dr. Charles J. Ashworth, a member of the health insurance committee of the State Society, and also president-elect of that Society, reviewed the history of negotiations between the Society and Blue Cross.

Many members participated in the general discussion, a report of which is filed with the official minutes of the meeting and is available to members at the Association's office.

The Association, by an overwhelming vote, went on record as giving a vote of confidence to the Health Insurance Committee of the State Medical Society for its work.

The meeting adjourned at 9:50 p.m.

Respectfully submitted:

DANIEL V. TROPPOLI, M.D., *Secretary*

PROVIDENCE MEDICAL ASSOCIATION

A regular meeting of the Providence Medical Association was held at the Medical Library on Monday, October 3, 1949.

The meeting was called to order by Dr. George W. Waterman, President, at 8:40 p.m.

Reading of Minutes

The reading of the minutes of the regular meeting held in May was omitted.

Report on Special Meeting

Dr. Troppoli reported on the special meeting of the Association held September 27, at which the Association went on record with a vote of confidence to the Health Insurance Committee of the Rhode Island Medical Society.

Announcement by the President

The President announced preliminary plans for the Second Statewide Cancer Conference for physicians to be held at the Medical Library on October 26. The President also announced that the Medical Bureau was in full operation, and members of the Association were invited to visit the Bureau.

Recommendations for Election to Membership

The Secretary reported that the Executive Committee at a recent meeting had reviewed applications for membership and voted to recommend election to active membership:

Oswald D. Cinquegrana, M.D.
Hilary Herbert Connor, M.D.
Charles Herbert Cronick, M.D.
Herbert Fanger, M.D.
Bertram L. Holdredge, M.D.

and to associate membership

Benecel L. Schiff, M.D., of the Pawtucket Medical Association

Nathan Sonkin, M.D., of the Pawtucket Medical Association

Dr. Louis I. Kramer moved the election of these physicians to membership. The motion was unanimously adopted.

Program of the Evening

Dr. Waterman announced that he had invited Mr. Richard Brown, Director of Family Service Inc., to explain the work of his agency to the membership.

Mr. Brown stressed there were four fields in which there are cross relationship of problems,—viz., dependency, health, maladjustment, and recreation. Usually only one problem does not exist in a family,—the family unit is also involved making multiple problems. Frequently the strength of the entire family may be undermined.

Mr. Brown recommends strongly integration of services for families with problems.

He makes a plea for the doctor, psychiatrist, and social worker to work together and utilize the services of each other.

This agency has an open door for patients with family problems.

Dr. Louis I. Kramer, Chairman of the Committee on Diabetes of the State Medical Society, announced plans for Diabetes Detection Week, October 10-16.

Dr. Kramer stressed the fact that for every known diabetic there is another that is not dis-

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covered. There is a predominence of males over females with diabetes therefore emphasis should be on males for examination. Diabetics should be treated early before complications set in, the treated ones do well, the untreated ones do poorly. He urged the cooperation of all the doctors in the state for diabetic detection week October 10-16.

* * *

The scientific paper of the evening was presented by Drs. Herman A. Lawson and William J. H. Fischer, the title of which was "Treatment of Malignant Lymphomas with Nitrogen Mustard."

Nitrogen mustard was first distributed by Merck to institutions to try on cases of malignant lymphomas.

It was first used by Goodman intravenously on six patients in the terminal stages of the disease with promising results.

Nitrogen mustard is a colorless crystalline, readily soluble substance, which is extremely active chemically, undergoing rapid change.

The following is the pharmacologic effect:

1. Parasympathetic (cholinergic). Stimulates the parasympathetic nervous system.
2. Nicotinic action on nerve.
3. Paralytic action.
4. Central action, nausea and vomiting.
5. Vesicant action.
6. Nucleotoxic action. It has a peculiar affinity for the nucleus. It produces mutations and in low concentrations will stop mitosis.
7. Leukopenic effect. It can cause complete dissolution of lymphoid tissue in twenty-four hours. This nucleotoxic action is most pronounced in actively growing tissue where mitotic sequence is interrupted. This action is very prompt within two to five minutes, therefore it melts down lymph nodes quickly.

Because of its vesicant property, it can only be given intravenously into a running I. V. of saline or D/W, an average of 7 mg. per day for four days.

The immediate toxic effect is nausea and vomiting and occasionally diarrhea. These effects can be minimized by sedation and atropine. All patients developed a leukopenia which may be quite brief.

The best results are obtained in lymphoma of the Hodgkins type. It is less effective in the lymphocytic type. It should be used in the late stage of the disease when x-ray is not helpful, and also when the disease is widespread.

In a large majority the good effect is brief. Dr. Fischer then presented two cases to show the results they achieved.

* * *

Dr. Charles J. Ashworth, President-Elect of the Rhode Island Medical Society, and a member of the Health Insurance Committee of the State Society, briefly discussed the surgical insurance program presented by the House of Delegates to the Blue Cross.

The recent proposal of the Rhode Island Medical Society by its House of Delegates as the solution to the problem that has engaged us for some time regarding the proposed surgical insurance follows the pattern proved most successful in other states.

The 1949 study of Voluntary Prepayment Medical Care Plans, issued this past summer by the Council on Medical Service of the American Medical Association, gives an excellent summary of the plans that have been adopted on both the state and county levels throughout the nation.

By the end of 1948 there were 42 states and the District of Columbia with plans enrolling subscribers. Here is a quick summary of how these state plans operate, with, or without, affiliation with the Blue Cross:

In 29 statewide plans the arrangement calls for separate corporations — that is, one corporation under the medical society's auspices, and one under the auspices of the hospitals—The Blue Cross Corporation. There are separate governing bodies and separate contracts. But all enrollment and business procedures are handled through the Blue Cross Hospital Service plan for both programs. The Blue Cross is paid proportionately for its work as the business agent for the medical service corporation.

In one state—West Virginia—there is not a single statewide plan, but rather 8 separate programs under various county jurisdictions. These eight plans in West Virginia break down into 4 with separate corporations from the Blue Cross, as just noted for the other States, 3 with no Blue Cross affiliation whatever, and 1 with a single corporation for both plans but with separate contracts.

Nine state plans have no Blue Cross affiliation whatever. These programs range from plans such as developed in Rhode Island, New Mexico, South Dakota, Illinois, and others using private insurance companies, to the Washington Plan organized in

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1933 as a coordinating agency to supervise and promote prepayment medical and hospital programs of its component members, and now operating with 24 county organizations under the direct supervision of the State Insurance Commissioner.

Six state plans operate with the surgical insurance as a rider to the Hospital service contract, thus allowing the Blue Cross to underwrite the surgery. However, it is most significant to us in our study that none of these six plans are service programs; on the contrary they are straight cash indemnity programs such as are offered by any insurance company. These plans are in Alabama, Arkansas, Delaware, Mississippi, Nevada, and North Carolina, and in only one plan does the medical profession have a minority representation such as it was offered here in Rhode Island where only one in every four directors on the Blue Cross medical service corporation is a doctor nominated by the Society.

Since we have been willing to have a service plan, with liberal income limits, the immediate concern is that we develop our plan along the pattern of successful statewide programs providing the combination service-indemnity contract. Twenty-three of the plans working with Blue Cross on the separate corporation, separate governing body, separate contract basis are the combination service-indemnity program. These plans include those in such states as Michigan, Massachusetts, Minnesota, New Jersey, Florida, New York and Pennsylvania, to mention a few.

The meeting adjourned at 10:40 p.m.

Attendance was 93. Collation was served.

Respectfully submitted,

DANIEL V. TROPPOLI, M.D., *Secretary*

PAWTUCKET MEDICAL ASSOCIATION

The regular monthly meeting of the Pawtucket Medical Association was held in the Nurses' Auditorium of Memorial Hospital at 12:00 noon on October 20, 1949. Eighteen members were present.

The applications for membership of Dr. Rudolph Alexander Jaworski and Dr. Dante Chiappinelli were reported back favorably from the Standing Committee to be submitted to ballot at the next regular meeting.

Dr. Earl Kelly spoke on, "Congenital Hypertrophic Pyloric Stenosis," illustrating some of the features with a number of colored films which demonstrated in particular the prominent transverse gastric peristaltic wave. Several pertinent x-rays contrasting pyloric stenosis and pyloric

spasm were shown. Dr. Edward Trainor commented on the surgical aspects of pyloric stenosis.

The meeting adjourned at 1:00 p.m.

Respectfully submitted,

K. W. HENNESSEY, M.D.

KENT COUNTY

The regular monthly meeting of the Kent County Medical Society was held on Tuesday, September 27, 1949, at the home of Dr. Arthur Hardy, President.

The meeting was called to order at 9:10 p.m. There were nineteen members present. The minutes of the last meeting were accepted as read.

Dr. Rocco Abbate then gave the recent developments concerning the Blue Cross controversy, and read a report from the Rhode Island Medical Society which had been intended for release to the public press. Dr. Abbate pointed out how the papers printed an incomplete report and used only what suited their purpose.

The members then voted unanimous approval on the following resolution:

Resolved:

That the Kent County Medical Society give a vote of confidence to the Health Insurance Committee of the Rhode Island Medical Society. It also expresses confidence that a final solution of the entire problem will be effected in the best interests of the public by the House of Delegates of the society at its meeting tomorrow night.

* * *

Dr. Young and Dr. Taggart then commended highly the work of the Health Insurance Committee.

Dr. Collom made a motion that the Kent County Medical Society pledge their support to the Diabetes Detection program which will be held the week of Oct. 10 to 16. Dr. Abbate seconded and it was so voted.

There followed an open discussion about the organization of the staff for the new hospital and, as requested by the Rhode Island Medical Society, the formation of a committee on hospital and professional regulations. A motion was made that the president nominate a committee of five to represent the Kent County Medical Society to the State Society and to the Board of Trustees of the hospital. This committee is to consist of four members with the president as a member ex-officio. The motion was also made that this standing committee be appointed now to represent the Medical Society until the end of the year and that the by-laws be amended to that effect. The motion was seconded and voted.

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MEDICAL LIBRARY NEWS

RECENT ACCESSIONS TO THE LIBRARY

HARVEY COLLECTION. Doctor N. Darrell Harvey's gift of 125 volumes has added many needed titles to our otolaryngological and ophthalmological holdings. We were very glad to receive recent *Transactions of the American Otological Society* and of the American Academy of Ophthalmology and Oto-Laryngology as we do not subscribe to these.

DAVENPORT COLLECTION. Doctor F. Ronchese gave the Collection a copy of Louis-Ferdinand Céline (Doctor Destouches)—*Voyage au Bout de la Nuit,* Paris, 1934. The following books were added by purchase:

Emerson C. Kelly — *Encyclopedia of Medical Sources,* Balt., 1948.

Henry A. Skinner—*The Origin of Medical Terms,* Balt., 1949.

Doctor Madelaine R. Brown, of Boston, presented the Library with a copy of Richard Wiseman—*Eight Chirurgical Treatises,* v. 1, Lond., 1734.

Two books were given us by Doctor Peter Pineo Chase:

Judith Robinson—*Tom Cullen of Baltimore,* Toronto, 1949.

William H. Woglom—*Discoverers for Medicine,* New Haven, 1949.

Doctor Charles L. Farrell gave the Library eight pictures, some pamphlets and journals.

GORMLY COLLECTION. Two books were added:

Leopold Brahdy & Samuel Kahn—*Trauma and Disease.* 2nd ed., Phil., 1941.

Louis J. Regan—*Doctor and Patient and the Law,* 2nd ed., St. L., 1949.

OTHER ADDITIONS:

Annual Reprint of the Council on Pharmacy and Chemistry of the American Medical Association for 1948. Chic., 1949.

George W. Bachman & Lewis Meriam—*The Issue of Compulsory Health Insurance.* Wash., 1948.

MISSING

Annals of Internal Medicine, September 1948 — Lancet, March 6, 1948

Andrew L. Banyai — *Pneumoperitoneum Treatment.* St. L., 1946.

Alvan L. Barach—*Physiologic Therapy in Respiratory Diseases.* 2nd ed. Phil., 1948.

Blakiston's *New Gould Medical Dictionary.* Phil., 1949.

Lawrence R. Boies & others—*Fundamentals of Otolaryngology.* Phil., 1949.

Willis C. Campbell — *Operative Orthopedics.* Edited by J. S. Speed and Hugh Smith. 2 vols. 2nd ed., St. L., 1949.

Frederick Christopher, editor — *A Textbook of Surgery by American Authors.* 5th ed. Phil., 1949.

Howard F. Conn, editor—*Current Therapy 1949.* Phil., 1949.

Margaret D. Corbett—*Help Yourself to Better Sight.* N. Y., 1949.

André Cournand & others—*Cardiac Catheterization in Congenital Heart Disease.* N. Y., 1949.

George Crile, Jr.—*Practical Aspects of Thyroid Disease.* Phil., 1949.

Wilburt C. Davison—*The Compleat Pediatrician.* Durham, N. C., 1949. 6th ed.

Elmer L. DeGowin & others—*Blood Transfusion.* Phil., 1949.

Directory of Medical Specialists, vol. IV., Chic., 1949.

Nathaniel W. Faxon—*The Hospital in Contemporary Life.* Cambridge, 1949.

Martin Gross & Leon A. Greenberg—*The Salicyclates.* New Haven, 1948.

Hugh C. Ilgenfritz—*Preoperative and Postoperative Care of Surgical Patients.* St. L., 1948.

Samuel L. Levine & W. Proctor Harvey—*Clinical Auscultation of the Heart.* Phil., 1949.

Philip Lewin—*The Foot and Ankle.* 3rd ed. rev. Phil., 1947.

Clarence W. Lieb—*Outwitting Your Years.* N. Y., 1949.

Harry R. Litchfield & Leon H. Dembo, editors—*Pediatric Progress.* Phil., 1948.

William R. Lyons & Barnes Woodhall—*Atlas of Peripheral Nerve Injuries.* Phil., 1949.

Manual of Serologic Tests for Syphilis. Federal Security Agency. Wash., 1949.

James S. McLester—*Nutrition and Diet in Health and Disease.* 5th ed. Phil., 1949.

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Frank L. Meleney—*Clinical Aspects and Treatment of Surgical Infections.* Phil., 1949.

George R. Moon—*How to Become a Doctor.* Phil., 1949.

Frank H. Netter, editor—*The Ciba Collection of Medical Illustrations.* Summit, N. J., 1948.

New and Nonofficial Remedies. Council on Pharmacy and Chemistry, American Medical Association. Phil., 1949.

Irvine H. Page & Arthur C. Corcoran—*Arterial Hypertension. Its Diagnosis and Treatment.* 2nd ed. Chic., 1949.

O. H. Perry Pepper—*Medical Etymology.* Phil., 1949.

Poliomyelitis. Papers and Discussions Presented at the First International Poliomyelitis Conference. Phil., 1949.

Joseph H. Pratt—*A Year With Osler.* Balt., 1949.

Alice L. Price—*The American Nurses Dictionary.* Phil., 1949. *Vocabulary Guide.* Phil., 1949.

Publishers' Trade List Annual. 2 vols. & index. N. Y., 1948. Gift of the Veterans Administration Hospital, Providence.

Wilmer S. Rich and Neva R. Deardorff—*American Foundations and Their Fields.* VI. N. Y., 1948.

Gardner M. Riley—*Essentials of Gynecologic Endocrinology.* Ann Arbor, 1948.

Maya Riviere—*Rehabilitation of the Handicapped. A Bibliography 1940-1946.* 2 vols. N. Y., 1949.

Robert E. Rothenberg and others—*Group Medicine and Health Insurance in Action.* N. Y., 1949.

Report of the Medical Officer of the Privy Council, 1858, 1861-1869. Gift of the Brown University Library.

Sesquicentennial Brochure, Chirurgical Faculty of the State of Maryland, 1799-1949.

Edwin M. Shearer—*Manual of Human Dissection.* Edited by Charles E. Tobin. 2nd ed. Phil., 1949.

James S. Simmons, editor—*Public Health in the World Today.* Cambridge, Mass., 1949.

Franklin F. Snyder — *Obstetric Analgesia and Anesthesia.* Phil., 1949.

Technical Bulletins, Veterans Administration, Vol. II, 1948. Gift of U. S. Government.

Paul Titus—Atlas of Obstetric Technic. 2nd ed. St. L., 1949.

Kurt H. Thoma—*Oral and Dental Diagnosis.* 3rd ed. Phil., 1949.

Melvin W. Thorner—*Psychiatry in General Practice.* Phil., 1948.

Transactions of the American Clinical and Climatological Association, vol. 60, 1948.

Transactions of the Third American Congress on Obstetrics and Gynecology. Portland, Oregon, 1948.

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Andreas Vesalius—*The Epitome.* Translated from the Latin with Preface and Introduction by L. R. Lind. N. Y., 1949.

Fredrick A. Willius & Thomas L. Dry—*A History of the Heart and Circulation.* Phil., 1948.

Theodore Wiprud—*The Business Side of Medical Practice.* 2nd ed. Phil., 1949.

Yearbook of General Therapeutics, 1948. Chic., 1949.

The 1949 Yearbook of Medicine. Chic., 1949.

The 1949 Yearbook of Radiology. Chic., 1949.

Acknowledgment of Books Received for Review

The Editor acknowledges the receipt of the following books which will be of value to the Library:

Shearer's Manual of Human Dissection. Edited by Charles E. Tobin. The Blakiston Co., Phil., 1949. 2nd ed. $4.50

Paul DeKruif—*Life Among the Doctors.* Harcourt, Brace & Co., N. Y., 1949. $4.75

BOOK REVIEW

CLINICAL BIOCHEMISTRY by Abraham Cantarow, M.D., and Max Trumper, Ph.D. W. B. Saunders Co., Philadelphia, 1949, 4th edition.

The 4th edition of this well-known text on CLINICAL BIOCHEMISTRY continues in the same style of earlier editions. The book primarily explains the application to clinical medicine of new discoveries and tests in Biochemistry.

New information concerning metabolism and Biochemistry fill the literature and make it impossible for a clinician to evaluate and apply these discoveries. Cantarow and Trumper appreciate the clinician's difficulty, but recognize his need and eagerness to apply this latest knowledge to the solution of his problems. The book, therefore, has this specific purpose—to bring together the latest and most valuable discoveries in Biochemistry, explain them clearly, and make them of practical usefulness to the clinician. When the clinician refers to this text for information on a given subject, the information is there in the pattern of his thinking, which is: (1) In a given disease, what biochemical laboratory tests are of help? (2) What usefulness in diagnosis and treatment is a particular test? (3) What, briefly, is the underlying biochemical mechanism?

It is this brief, direct, clinical approach to Biochemistry which makes this text extremely popular with physicians in general, and an invaluable aid to the internist.

ROBERT V. LEWIS, M.D.

KENT COUNTY SOCIETY

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Dr. Hardy, as chairman, chose the following members to comprise the committee. Drs. Young, Wittig, Collom, and Taggart.

The Secretary was directed to send this information to the Board of Trustees and to notify the Rhode Island Medical Society of the choice of the committee.

A report from the treasurer, Dr. Mack, was received and recorded and filed.

An application to membership in the Kent County Medical Society was received from Dr. Daniel S. Harrop, Jr., and ordered sent to the Board of Censors for action.

A motion was made and passed unanimously that the Kent County Medical Society go on record as being totally opposed to any form of Compulsory Health Insurance. A copy of the resolution was ordered sent to the State Society and to the two state representatives, and two State senators.

The meeting adjourned at 11 p.m.

Respectfully submitted,

JEAN M. MAYNARD, *Secretary*

KENT COUNTY

The October meeting of the Kent County Medical Society was called to order at 9:15 p.m. on October 25, 1949, at the home of the president, Dr. Hardy, with thirteen members and one guest speaker present.

The minutes of the September meeting were read and accepted.

A new by-law on the formation of a committee on Hospitals and Professional Regulations which was to be voted on at this meeting was postponed to the November meeting for the purpose of correction and elaboration.

Dr. Taggart made a motion that the president name a Committee that will revise and have an up-to-date reprint made of the Constitution and By-Laws of the Society. He also suggested that the president, vice-president, and secretary form this Committee, and it was so voted.

Dr. Daniel S. Harrop, Jr., was admitted to associate membership in the Society after a motion made by Dr. Collom and seconded by Dr. Erinakes.

Dr. Charles A. Millard, Rhode Island president for the American Academy of General Practice spoke about this group, which was first founded in Atlantic City in June, 1947, at the 100th Anniversary of the A.M.A.

He pointed out the trend to over specialization in recent years, and discussed the purpose of the American Academy of General Practice, which is to group and make better general practitioners who are the bulwark against socialized medicine.

The qualities of an active member of A.A.G.P. in Rhode Island are as follows:

He must be a member of the County and State Societies and of the A.M.A.

He must have three years of general practice.

He must have had one year of rotating internship.

He must complete 150 hours of postgraduate work in 3 years, 50 hours of which must be formal teachings recognized by the Council on Medical Education of the A.M.A.

A rising vote of thanks was accorded Dr. Millard for his interesting talk.

The meeting adjourned at 11:10 p.m.

Respectfully submitted,

JEAN M. MAYNARD, M.D., *Secretary*

HOUSE OF DELEGATES

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throughout the country by the Federal Bureau of Investigation regarding the development of medical care plans by state medical societies.

Directors on Blue Cross Board

Dr. Ashworth initiated discussion regarding the Society's representatives on the Board of Directors of Blue Cross. He pointed out that the Society had only one director until an agreement was signed to permit the Blue Cross to become a Medical Service Corporation, and at that time when it was apparent that Blue Cross would operate a surgical program the number of medical society directors on its board was increased by six. Dr. Ashworth suggested that the House of Delegates consider the termination of the appointment of the six additional directors.

The question was discussed but no action was taken and it was suggested that the problem be reviewed by the House of Delegates at its regular meeting in January.

The House adjourned at 10:55 p.m.

Respectfully submitted,

MORGAN CUTTS, M.D., *Secretary*

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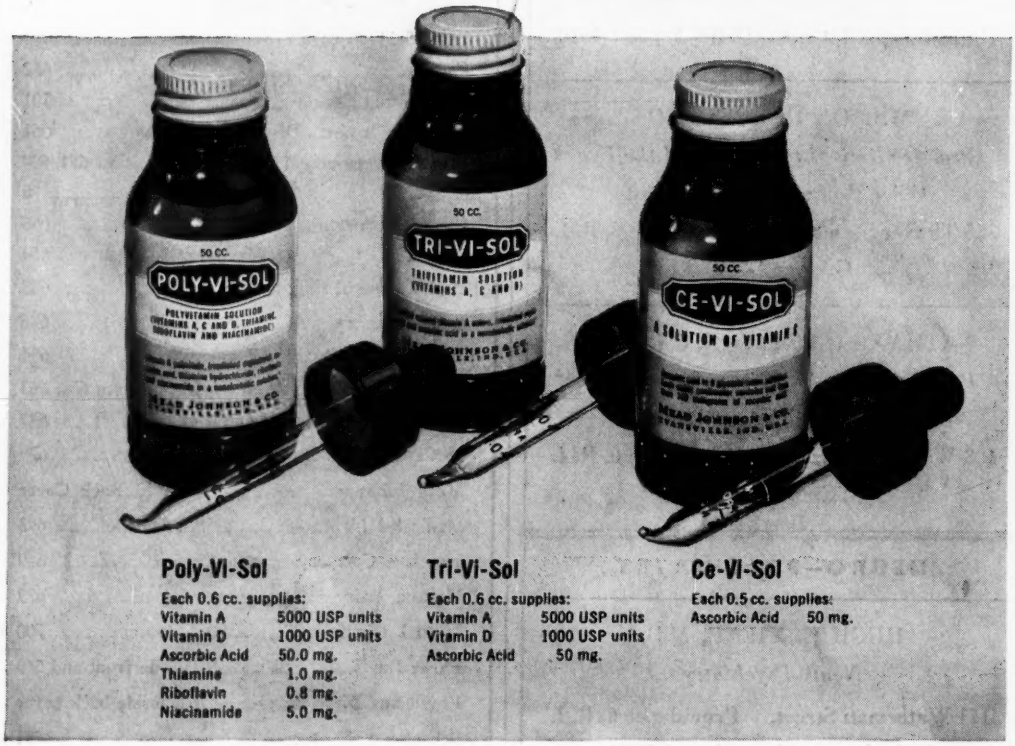

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